

NATIONAL QUALITY FORUM

Measure Evaluation 4.1 December 2009

This form contains the measure information submitted by stewards. Blank fields indicate no information was provided. Attachments also may have been submitted and are provided to reviewers. The subcriteria and most of the footnotes from the evaluation criteria are provided in Word comments within the form and will appear if your cursor is over the highlighted area. Hyperlinks to the evaluation criteria and ratings are provided in each section.

TAP/Workgroup (if utilized): Complete all **yellow highlighted** areas of the form. Evaluate the extent to which each subcriterion is met. Based on your evaluation, summarize the strengths and weaknesses in each section.

Note: *If there is no TAP or workgroup, the SC also evaluates the subcriteria (yellow highlighted areas).*

Steering Committee: Complete all **pink** highlighted areas of the form. Review the workgroup/TAP assessment of the subcriteria, noting any areas of disagreement; then evaluate the extent to which each major criterion is met; and finally, indicate your recommendation for the endorsement. Provide the rationale for your ratings.

Evaluation ratings of the extent to which the criteria are met

C = Completely (unquestionably demonstrated to meet the criterion)

P = Partially (demonstrated to partially meet the criterion)

M = Minimally (addressed BUT demonstrated to only minimally meet the criterion)

N = Not at all (NOT addressed; OR incorrectly addressed; OR demonstrated to NOT meet the criterion)

NA = Not applicable (only an option for a few subcriteria as indicated)

(for NQF staff use) NQF Review #: PSM-038-10 NQF Project: Patient Safety Measures
MEASURE DESCRIPTIVE INFORMATION
De.1 Measure Title: Unplanned admission to neonatal intensive care unit at term.
De.2 Brief description of measure: The rate of admission to the neonatal intensive care unit (NICU) (or transfer to another institution in hospitals that do not provide NICU care) for more than 24 hours of live inborns at => 37 weeks gestation and => 2500 grams.
1.1-2 Type of Measure: Outcome De.3 If included in a composite or paired with another measure, please identify composite or paired measure Adverse Outcome Index, Weighted Adverse Outcome Score, Severity Index
De.4 National Priority Partners Priority Area: Safety De.5 IOM Quality Domain: Safety De.6 Consumer Care Need: Staying healthy

CONDITIONS FOR CONSIDERATION BY NQF	
Four conditions must be met before proposed measures may be considered and evaluated for suitability as voluntary consensus standards:	NQF Staff
A. The measure is in the public domain or an intellectual property (measure steward agreement) is signed. <i>Public domain only applies to governmental organizations. All non-government organizations must sign a measure steward agreement even if measures are made publicly and freely available.</i> A.1 Do you attest that the measure steward holds intellectual property rights to the measure and the right to use aspects of the measure owned by another entity (e.g., risk model, code set)? Yes A.2 Indicate if Proprietary Measure (as defined in measure steward agreement): A.3 Measure Steward Agreement: Agreement will be signed and submitted prior to or at the time of measure submission A.4 Measure Steward Agreement attached:	A Y <input type="checkbox"/> N <input type="checkbox"/>

<p>B. The measure owner/steward verifies there is an identified responsible entity and process to maintain and update the measure on a schedule that is commensurate with the rate of clinical innovation, but at least every 3 years. Yes, information provided in contact section</p>	<p>B Y <input type="checkbox"/> N <input type="checkbox"/></p>
<p>C. The intended use of the measure includes <u>both</u> public reporting <u>and</u> quality improvement. ► Purpose: Public reporting, Internal quality improvement</p>	<p>C Y <input type="checkbox"/> N <input type="checkbox"/></p>
<p>D. The requested measure submission information is complete. Generally, measures should be fully developed and tested so that all the evaluation criteria have been addressed and information needed to evaluate the measure is provided. Measures that have not been tested are only potentially eligible for a time-limited endorsement and in that case, measure owners must verify that testing will be completed within 12 months of endorsement. D.1 Testing: Yes, fully developed and tested D.2 Have NQF-endorsed measures been reviewed to identify if there are similar or related measures? Yes</p>	<p>D Y <input type="checkbox"/> N <input type="checkbox"/></p>
<p>(for NQF staff use) Have all conditions for consideration been met? Staff Notes to Steward (if submission returned):</p>	<p>Met Y <input type="checkbox"/> N <input type="checkbox"/></p>
<p>Staff Notes to Reviewers (issues or questions regarding any criteria):</p>	
<p>Staff Reviewer Name(s):</p>	

<p>TAP/Workgroup Reviewer Name:</p>	
<p>Steering Committee Reviewer Name:</p>	
<p>1. IMPORTANCE TO MEASURE AND REPORT</p>	
<p>Extent to which the specific measure focus is important to making significant gains in health care quality (safety, timeliness, effectiveness, efficiency, equity, patient-centeredness) and improving health outcomes for a specific high impact aspect of healthcare where there is variation in or overall poor performance. Measures must be judged to be important to measure and report in order to be evaluated against the remaining criteria. (evaluation criteria) 1a. High Impact</p>	<p>Eval Ratin g</p>
<p>(for NQF staff use) Specific NPP goal:</p>	
<p>1a.1 Demonstrated High Impact Aspect of Healthcare: Patient/societal consequences of poor quality, Other 1a.2 Addresses NPP Goal: Safety 1a.3 Summary of Evidence of High Impact: Delivery is one the most frequent reasons for admission to a hospital; an unplanned, possibly preventable admission to the NICU of a full term neonate can cause significant stress to the mother and family. 1a.4 Citations for Evidence of High Impact:</p>	<p>1a C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/></p>
<p>1b. Opportunity for Improvement 1b.1 Benefits (improvements in quality) envisioned by use of this measure: Obstetric management influences term NICU admission rates. Induction of labor and unfavorable Bishop score (both modifiable events) are predictors of admission to the NICU. Recent data suggest that elective delivery before 39 weeks gestation is a strong predictor of unplanned NICu admission. 1) Tan PC, Suguna S, Vallikkannu N, Hassan J. Predictors of newborn admission after labour induction at term: Bishop score, pre-induction ultrasonography and clinical risk factors. Singapore Med J. 2008; 49:193-8.</p>	<p>1b C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/></p>

2) Tracy SK, Tracy MB, Sullivan E. Admission of term infants to neonatal intensive care: a population-based study. *Birth*. 2008;35:259.

3) Alan TN, et al. Timing of Elective repeat Cesarean Delivery at Term and Neonatal Outcome. *NEJM*. 2009; 360:111-120.

1b.2 Summary of data demonstrating performance gap (variation or overall poor performance) across providers:

1b.3 Citations for data on performance gap:

1b.4 Summary of Data on disparities by population group:
Data suggest the socio-economic factors influence NICU admission rates.

1b.5 Citations for data on Disparities:
1) Manning D, Brewster B, Bundred P. Social deprivation and admission for neonatal care. *Arch Dis Child Fetal Neonatal Ed*. 2005;90:F337-8.

1c. Outcome or Evidence to Support Measure Focus

1c.1 Relationship to Outcomes (*For non-outcome measures, briefly describe the relationship to desired outcome. For outcomes, describe why it is relevant to the target population*): Neonatal intensive care admission occurs in approximately 6-8% of term births. This is thus a marker for significant neonatal morbidity.

1) Tracy SK, Tracy MB, Sullivan E. Admission of term infants to neonatal intensive care: a population-based study. *Birth*. 2008;35:259.

1c.2-3. Type of Evidence:

1c.4 Summary of Evidence (*as described in the criteria; for outcomes, summarize any evidence that healthcare services/care processes influence the outcome*):

1c.5 Rating of strength/quality of evidence (*also provide narrative description of the rating and by whom*):

1c.6 Method for rating evidence:

1c.7 Summary of Controversy/Contradictory Evidence:

1c.8 Citations for Evidence (*other than guidelines*):

1c.9 Quote the Specific guideline recommendation (*including guideline number and/or page number*):

1c.10 Clinical Practice Guideline Citation:

1c.11 National Guideline Clearinghouse or other URL:

1c.12 Rating of strength of recommendation (*also provide narrative description of the rating and by whom*):

1c.13 Method for rating strength of recommendation (*If different from USPSTF system, also describe*

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<p><i>rating and how it relates to USPSTF):</i></p> <p>1c.14 Rationale for using this guideline over others:</p>	
<p>TAP/Workgroup: What are the strengths and weaknesses in relation to the subcriteria for <i>Importance to Measure and Report</i>?</p>	1
<p>Steering Committee: Was the threshold criterion, <i>Importance to Measure and Report</i>, met? Rationale:</p>	<p>1 Y <input type="checkbox"/> N <input type="checkbox"/></p>
<p>2. SCIENTIFIC ACCEPTABILITY OF MEASURE PROPERTIES</p>	
<p>Extent to which the measure, <u>as specified</u>, produces consistent (reliable) and credible (valid) results about the quality of care when implemented. (evaluation criteria)</p>	<p>Eval Ratin g</p>
<p>2a. MEASURE SPECIFICATIONS</p>	
<p>S.1 Do you have a web page where current detailed measure specifications can be obtained? S.2 If yes, provide web page URL:</p> <p>2a. Precisely Specified</p>	
<p>2a.1 Numerator Statement (<i>Brief, text description of the numerator - what is being measured about the target population, e.g. target condition, event, or outcome</i>): All live inborns who meet the criteria, excluding those with congenital anomalies or fetal hydrops.</p>	
<p>2a.2 Numerator Time Window (<i>The time period in which cases are eligible for inclusion in the numerator</i>): Occuring during delivery hospitalization</p>	
<p>2a.3 Numerator Details (<i>All information required to collect/calculate the numerator, including all codes, logic, and definitions</i>): Inborns only BW 2500 grams, GA 37 weeks, and NICU admission (day or charge) within one day of birth for greater than a day. Excludes cases with congenital anomalies (DX codes 740-759.9) and fetal hydrops (DX code 778.0), OR (Inborns with BW 2500 grams and GA 37 weeks AND transferred to another hospital (UB92/UB04 disp=02 or =05) within 1 day of birth and excluding cases with congenital anomalies DX codes 740-759.9) or fetal hydrops (DX code 778.0)</p>	
<p>2a.4 Denominator Statement (<i>Brief, text description of the denominator - target population being measured</i>): All live inborn infants during period of evaluation.</p>	
<p>2a.5 Target population gender: Male, Female 2a.6 Target population age range: Newborns</p>	
<p>2a.7 Denominator Time Window (<i>The time period in which cases are eligible for inclusion in the denominator</i>): Same as numerator</p>	
<p>2a.8 Denominator Details (<i>All information required to collect/calculate the denominator - the target population being measured - including all codes, logic, and definitions</i>): For the AOI and WAOS: DRG 370-375 or MS DRG 765-768 and 774-775</p>	<p>2a- specs C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/></p>
<p>2a.9 Denominator Exclusions (<i>Brief text description of exclusions from the target population</i>): None</p>	
<p>2a.10 Denominator Exclusion Details (<i>All information required to collect exclusions to the denominator,</i></p>	

<i>including all codes, logic, and definitions):</i>	
2a.11 Stratification Details/Variables <i>(All information required to stratify the measure including the stratification variables, all codes, logic, and definitions):</i> None	
2a.12-13 Risk Adjustment Type: No risk adjustment necessary	
2a.14 Risk Adjustment Methodology/Variables <i>(List risk adjustment variables and describe conceptual models, statistical models, or other aspects of model or method):</i>	
2a.15-17 Detailed risk model available Web page URL or attachment:	
2a.18-19 Type of Score: Rate/proportion 2a.20 Interpretation of Score: Better quality = Lower score 2a.21 Calculation Algorithm <i>(Describe the calculation of the measure as a flowchart or series of steps):</i> Admission to NICU of neonate birthweight >=2500 grams and >= 37 weeks gestational age (GA)* for >1 day Inborns only BW >= 2500 grams, GA >= 37 weeks, and NICU admission (day or charge) within one day of birth for greater than a day. Excludes cases with congenital anomalies (DX codes 740-759.9) OR If the hospital does not provide NICU services the algorithm is modified to identify inborns transferred out: (Inborns with BW>=2500 grams and GA >= 37 weeks AND transferred to another hospital (UB92 disp=02 or =05) within 1 day of birth and excluding cases with congenital anomalies DX codes 740-759.9)	
2a.22 Describe the method for discriminating performance <i>(e.g., significance testing):</i> See AOI composite submission.	
2a.23 Sampling (Survey) Methodology <i>If measure is based on a sample (or survey), provide instructions for obtaining the sample, conducting the survey and guidance on minimum sample size (response rate):</i>	
2a.24 Data Source <i>(Check the source(s) for which the measure is specified and tested)</i> Electronic administrative data/claims, Electronic clinical data, Electronic Health/Medical Record	
2a.25 Data source/data collection instrument <i>(Identify the specific data source/data collection instrument, e.g. name of database, clinical registry, collection instrument, etc.):</i> Administrative data set, UB04, perinatal or L&D intrapartum record.	
2a.26-28 Data source/data collection instrument reference web page URL or attachment:	
2a.29-31 Data dictionary/code table web page URL or attachment: URL www.npic.org See AOI Sample Report	
2a.32-35 Level of Measurement/Analysis <i>(Check the level(s) for which the measure is specified and tested)</i> Can be measured at all levels	
2a.36-37 Care Settings <i>(Check the setting(s) for which the measure is specified and tested)</i> Hospital	
2a.38-41 Clinical Services <i>(Healthcare services being measured, check all that apply)</i> Clinicians: Nurses, Clinicians: PA/NP/Advanced Practice Nurse, Clinicians: Physicians (MD/DO)	
TESTING/ANALYSIS	
2b. Reliability testing	2b C <input type="checkbox"/> P <input type="checkbox"/>
2b.1 Data/sample <i>(description of data/sample and size):</i> Administrative data for Beth Israel Deaconess	P <input type="checkbox"/>

<p>Medical Center for the period Q 3, 2005- Q2 2006 was reconciled with abstracted data for the same period.</p> <p>2b.2 Analytic Method (<i>type of reliability & rationale, method for testing</i>): Case by case review</p> <p>2b.3 Testing Results (<i>reliability statistics, assessment of adequacy in the context of norms for the test conducted</i>): Exclusions were important since inborns with these complications are appropriate for admission to the NICU. Remaining cases were accurately identified using the administrative and UB04 (claims) data.</p>	<p>M <input type="checkbox"/></p> <p>N <input type="checkbox"/></p>
<p>2c. Validity testing</p> <p>2c.1 Data/sample (<i>description of data/sample and size</i>): Beth Israel Deconess Medical Center has been tracking this adverse event as part of their Adverse Outcome Index since early 2001.</p> <p>2c.2 Analytic Method (<i>type of validity & rationale, method for testing</i>): Chart review and analysis of the administrative data set for all deliveries during the period.</p> <p>2c.3 Testing Results (<i>statistical results, assessment of adequacy in the context of norms for the test conducted</i>): Reduction of NICU admissions >=2500 grams has improved neonatal safety.</p>	<p>2c</p> <p>C <input type="checkbox"/></p> <p>P <input type="checkbox"/></p> <p>M <input type="checkbox"/></p> <p>N <input type="checkbox"/></p>
<p>2d. Exclusions Justified</p> <p>2d.1 Summary of Evidence supporting exclusion(s): Congenital anomalies and fetal hydrops frequently lead to neonatal morbidity and mortality. These babies are frequently and appropriately admitted to the NICU and are often >= 2500 grams. Since this measure is designed to identify preventable adverse events on labor and delivery, inclusion of NICU admissions for these populations would inappropriately dilute the sampling.</p> <p>2d.2 Citations for Evidence: Up to Date. Accessed January 29, 2009. http://utdol.com/online/content/topic.do?topicKey=neonatal/14943&selectedTitle=1-134&source=search_result</p> <p>2d.3 Data/sample (<i>description of data/sample and size</i>):</p> <p>2d.4 Analytic Method (<i>type analysis & rationale</i>):</p> <p>2d.5 Testing Results (<i>e.g., frequency, variability, sensitivity analyses</i>):</p>	<p>2d</p> <p>C <input type="checkbox"/></p> <p>P <input type="checkbox"/></p> <p>M <input type="checkbox"/></p> <p>N <input type="checkbox"/></p> <p>NA <input type="checkbox"/></p>
<p>2e. Risk Adjustment for Outcomes/ Resource Use Measures</p> <p>2e.1 Data/sample (<i>description of data/sample and size</i>):</p> <p>2e.2 Analytic Method (<i>type of risk adjustment, analysis, & rationale</i>):</p> <p>2e.3 Testing Results (<i>risk model performance metrics</i>):</p> <p>2e.4 If outcome or resource use measure is not risk adjusted, provide rationale:</p>	<p>2e</p> <p>C <input type="checkbox"/></p> <p>P <input type="checkbox"/></p> <p>M <input type="checkbox"/></p> <p>N <input type="checkbox"/></p> <p>NA <input type="checkbox"/></p>
<p>2f. Identification of Meaningful Differences in Performance</p> <p>2f.1 Data/sample from Testing or Current Use (<i>description of data/sample and size</i>): This measure has been individually tracked as part of a composite measure. It has been used in three published reports (see references), totalling more than 50,000 deliveries. In addition, the National Perinatal Information center</p>	<p>2f</p> <p>C <input type="checkbox"/></p> <p>P <input type="checkbox"/></p> <p>M <input type="checkbox"/></p> <p>N <input type="checkbox"/></p>

<p>has tracked this across a wide range of clinical settings, totally nearly 500,000 deliveries.</p> <p>1) Nielsen PE, Goldman MB, Mann S, Shapiro DE, Marcus RG, Pratt SD, et al. Effects of teamwork training on adverse outcomes and process of care in labor and delivery: a randomized controlled trial. <i>Obstet Gynecol</i> 2007; 109:48-55.</p> <p>2) Pratt SD, Mann S, Salisbury M, et al. Impact of CRM-based team training on obstetric outcomes and clinicians' patient safety attitude. <i>Joint Commission Journal on Quality and Patient Safety</i> 2007; 33:720-5.</p> <p>3) Nicholson JM, Parry S, Caughey AB, et al. The impact of the active management of risk in pregnancy at term on birth outcomes: a randomized clinical trial. <i>Am J Obstet Gynecol.</i> 2008; 198:511.e1-15.</p> <p>2f.2 Methods to identify statistically significant and practically/meaningfully differences in performance (type of analysis & rationale): See AOI composite submission</p> <p>2f.3 Provide Measure Scores from Testing or Current Use (description of scores, e.g., distribution by quartile, mean, median, SD, etc.; identification of statistically significant and meaningfully differences in performance):</p>	
<p>2g. Comparability of Multiple Data Sources/Methods</p> <p>2g.1 Data/sample (description of data/sample and size):</p> <p>2g.2 Analytic Method (type of analysis & rationale):</p> <p>2g.3 Testing Results (e.g., correlation statistics, comparison of rankings):</p>	<p>2g</p> <p>C <input type="checkbox"/></p> <p>P <input type="checkbox"/></p> <p>M <input type="checkbox"/></p> <p>N <input type="checkbox"/></p> <p>NA <input type="checkbox"/></p>
<p>2h. Disparities in Care</p> <p>2h.1 If measure is stratified, provide stratified results (scores by stratified categories/cohorts):</p> <p>2h.2 If disparities have been reported/identified, but measure is not specified to detect disparities, provide follow-up plans:</p>	<p>2h</p> <p>C <input type="checkbox"/></p> <p>P <input type="checkbox"/></p> <p>M <input type="checkbox"/></p> <p>N <input type="checkbox"/></p> <p>NA <input type="checkbox"/></p>
<p>TAP/Workgroup: What are the strengths and weaknesses in relation to the subcriteria for <i>Scientific Acceptability of Measure Properties</i>?</p>	<p>2</p>
<p>Steering Committee: Overall, to what extent was the criterion, <i>Scientific Acceptability of Measure Properties</i>, met? Rationale:</p>	<p>2</p> <p>C <input type="checkbox"/></p> <p>P <input type="checkbox"/></p> <p>M <input type="checkbox"/></p> <p>N <input type="checkbox"/></p>
3. USABILITY	
<p>Extent to which intended audiences (e.g., consumers, purchasers, providers, policy makers) can understand the results of the measure and are likely to find them useful for decision making. (evaluation criteria)</p>	<p>Eval Ratin g</p>
<p>3a. Meaningful, Understandable, and Useful Information</p> <p>3a.1 Current Use: In use</p> <p>3a.2 Use in a public reporting initiative (disclosure of performance results to the public at large) (If used in a public reporting initiative, provide name of initiative(s), locations, Web page URL(s). <u>If not publicly reported</u>, state the plans to achieve public reporting within 3 years):</p>	<p>3a</p> <p>C <input type="checkbox"/></p> <p>P <input type="checkbox"/></p> <p>M <input type="checkbox"/></p> <p>N <input type="checkbox"/></p>

<p>3a.3 If used in other programs/initiatives (If used in quality improvement or other programs/initiatives, name of initiative(s), locations, Web page URL(s). <u>If not used for QI</u>, state the plans to achieve use for QI within 3 years): This measure is one of 10 adverse events of the AOI composite measure and has a weight of 35. It is current being tracked by all Team Performance Plus clients, a subset of NPIC member hospitals, hospitals in the Maryland Perinatal Patient Safety Initiative, the Premier Perinatal Patient Safety Initiative and the Navy Military Treatment Facilities.</p> <p>Testing of Interpretability (Testing that demonstrates the results are understood by the potential users for public reporting and quality improvement)</p> <p>3a.4 Data/sample (description of data/sample and size): See AOI Composite submission.</p> <p>3a.5 Methods (e.g., focus group, survey, QI project): See AOI Composite submission.</p> <p>3a.6 Results (qualitative and/or quantitative results and conclusions): See AOI Composite submission.</p>	
<p>3b/3c. Relation to other NQF-endorsed measures</p> <p>3b.1 NQF # and Title of similar or related measures:</p>	
<p>(for NQF staff use) Notes on similar/related endorsed or submitted measures:</p>	
<p>3b. Harmonization If this measure is related to measure(s) already endorsed by NQF (e.g., same topic, but different target population/setting/data source <u>or</u> different topic but same target population):</p> <p>3b.2 Are the measure specifications harmonized? If not, why?</p>	<p>3b C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/></p>
<p>3c. Distinctive or Additive Value</p> <p>3c.1 Describe the distinctive, improved, or additive value this measure provides to existing NQF-endorsed measures:</p> <p>5.1 If this measure is similar to measure(s) already endorsed by NQF (i.e., on the same topic and the same target population), Describe why it is a more valid or efficient way to measure quality:</p>	<p>3c C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/></p>
<p>TAP/Workgroup: What are the strengths and weaknesses in relation to the subcriteria for <i>Usability</i>?</p>	<p>3</p>
<p>Steering Committee: Overall, to what extent was the criterion, <i>Usability</i>, met? Rationale:</p>	<p>3 C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/></p>
4. FEASIBILITY	
<p>Extent to which the required data are readily available, retrievable without undue burden, and can be implemented for performance measurement. (evaluation criteria)</p>	<p>Eval Rating</p>
<p>4a. Data Generated as a Byproduct of Care Processes</p> <p>4a.1-2 How are the data elements that are needed to compute measure scores generated? Data generated as byproduct of care processes during care delivery (Data are generated and used by</p>	<p>4a C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/></p>

<p>healthcare personnel during the provision of care, e.g., blood pressure, lab value, medical condition), Coding/abstraction performed by someone other than person obtaining original information (E.g., DRG, ICD-9 codes on claims, chart abstraction for quality measure or registry)</p>	<p>N <input type="checkbox"/></p>
<p>4b. Electronic Sources</p> <p>4b.1 Are all the data elements available electronically? (<i>elements that are needed to compute measure scores are in defined, computer-readable fields, e.g., electronic health record, electronic claims</i>) Yes</p> <p>4b.2 If not, specify the near-term path to achieve electronic capture by most providers.</p>	<p>4b C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/></p>
<p>4c. Exclusions</p> <p>4c.1 Do the specified exclusions require additional data sources beyond what is required for the numerator and denominator specifications? No</p> <p>4c.2 If yes, provide justification.</p>	<p>4c C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/></p>
<p>4d. Susceptibility to Inaccuracies, Errors, or Unintended Consequences</p> <p>4d.1 Identify susceptibility to inaccuracies, errors, or unintended consequences of the measure and describe how these potential problems could be audited. If audited, provide results. Not all hospitals provide NICU services; many transfer out these cases so it was necessary to develop an algorithm that would capture these cases and not penalize hospitals that do have a NICU and keep these cases. Additionally, NICU activity is identified through revenue codes on the UB 04 claims file. Hospitals that underuse, overuse or do not use the NICU revenue code may see an inaccurate count of their cases for this measure. Providing case counts to the hospitals during the validation/reporting process can assist hospitals in identifying if they have a problem in this area whether they have a NICU or not. These potential problems were audited during testing. Most cases were correctly identified; especially for those hospitals with NICU services. Hospitals without NICU services had to reconcile their numbers with their transfer activity and in most instances the case counts were correct.</p>	<p>4d C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/></p>
<p>4e. Data Collection Strategy/Implementation</p> <p>4e.1 Describe what you have learned/modified as a result of testing and/or operational use of the measure regarding data collection, availability of data/missing data, timing/frequency of data collection, patient confidentiality, time/cost of data collection, other feasibility/ implementation issues: Administrative data has improved greatly over the years such that it is a very viable source for calculating quality measure/indicator rates. It is a standard data set across all health care facilities, maintains patient confidentiality, is cost effective to collect and analyze, and can be collected at reasonable intervals (monthly, quarterly etc) so as to identify improvements or deterioration in patient safety. As with any measuring system, facilities being measured should have the opportunity to review and validate their data prior to their final rate calculations. Numerator case lists can be generated using medical record numbers present on most administrative data sets. Chart review to confirm or correct numerator cases has proven very effective in validating measure rates</p> <p>4e.2 Costs to implement the measure (<i>costs of data collection, fees associated with proprietary measures</i>): See AOI Composite submission.</p>	<p>4e C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/></p>

<p>4e.3 Evidence for costs: See AOI Composite submission.</p> <p>4e.4 Business case documentation: See AOI Composite submission.</p>	
<p>TAP/Workgroup: What are the strengths and weaknesses in relation to the subcriteria for <i>Feasibility</i>?</p>	<p>4</p>
<p>Steering Committee: Overall, to what extent was the criterion, <i>Feasibility</i>, met? Rationale:</p>	<p>4</p> <p>C <input type="checkbox"/></p> <p>P <input type="checkbox"/></p> <p>M <input type="checkbox"/></p> <p>N <input type="checkbox"/></p>
RECOMMENDATION	
<p>(for NQF staff use) Check if measure is untested and only eligible for time-limited endorsement.</p>	<p>Time-limited <input type="checkbox"/></p>
<p>Steering Committee: Do you recommend for endorsement? Comments:</p>	<p>Y <input type="checkbox"/></p> <p>N <input type="checkbox"/></p> <p>A <input type="checkbox"/></p>
CONTACT INFORMATION	
<p>Co.1 Measure Steward (Intellectual Property Owner) Co.1 Organization Department of OB/Gyn. Beth Israel Deaconess Medical Center, 330 Brookline Ave, Boston, Massachusetts, 02215</p> <p>Co.2 Point of Contact Janet, Muri, MBA, jmuri@npic.org, 401-274-0650-105</p>	
<p>Measure Developer If different from Measure Steward Co.3 Organization Department of OB/Gyn. Beth Israel Deaconess Medical Center, 330 Brookline Ave, Boston, Massachusetts, 02215</p> <p>Co.4 Point of Contact Janet, Muri, MBA, jmuri@npic.org, 401-274-0650-105</p>	
<p>Co.5 Submitter If different from Measure Steward POC Janet, Muri, MBA, jmuri@npic.org, 401-274-0650-105, National Perinatal Information Center</p>	
<p>Co.6 Additional organizations that sponsored/participated in measure development</p>	
ADDITIONAL INFORMATION	
<p>Workgroup/Expert Panel involved in measure development Ad.1 Provide a list of sponsoring organizations and workgroup/panel members' names and organizations. Describe the members' role in measure development. Peter E. Nielsen, MD; Marlene B. Goldman, ScD; Susan Mann, MD; David E. Shapiro, PhD; Ronald G. Marcus, MB, BCh; Stephen D. Pratt, MD; Penny Greenberg, RN; Patricia McNamee, RN, MS; Mary Salisbury, RN, MSN; David J. Birnbach, MD; Paul A. Gluck, MD; Mark D. Pearlman, MD; Heidi King, MS; David N. Tornberg, MD MPH; Benjamin P. Sachs, MB, BS; Lauren Bales, MD, Naval Medical Center Camp Pendleton; Ronald Burkman, MD, Baystate Medical Center; Cynthia Brumfield, MD, University of Alabama at Birmingham Hospital; Peter Cherouny, MD, University of Vermont-Fletcher Allen Health Care; Jack Cooley, MD, National Naval Medical Center; Harold Fox, MD, Johns Hopkins Medical Center; Elizabeth Golladay, MD, Tripler Army Medical Center; Lynn Leventis, MD, Naval Medical Center of San Diego; Robert Lorenz, MD, William Beaumont Hospital; William Lucky, MD, Baptist Hospital of Miami; Patrick Nugent, MD, South Shore Hospital; Spike Lipschitz, MD, South Shore Hospital; Chris Stolle, MD, Naval Medical Center of Portsmouth; Cosmas van DeVen, MD, University of Michigan Medical Center; Frank Witter, MD, Johns Hopkins Medical Center.</p> <p>In addition, representatives from the American College of Obstetrics and Gynecology, the American Society of</p>	

<p>Anesthesiologists, Association of Women’s Health Obstetric and Neonatal Nurses; the Society for Obstetric Anesthesia and Perinatology; the Armed Forces Institute of Pathology; the U.S. Navy Bureau of Medicine and Surgery; the Office of the Surgeon General, U.S. Army; and TRICARE Management Activity were present.</p> <p>Consensus panels were developed for the identification of measure to be included in the composite measure (AOI). This included vetting each of the individual measures. See reference for full description of panel process</p> <p>1) Mann S, Pratt SD et al. Assessing Quality in Obstetrical Care: Development of Standardized Measures. Jt Comm J Qual Pt Safety. 2006; 32 (9):497-505.</p>
<p>Ad.2 If adapted, provide name of original measure: Ad.3-5 If adapted, provide original specifications URL or attachment</p>
<p>Measure Developer/Steward Updates and Ongoing Maintenance Ad.6 Year the measure was first released: 2007 Ad.7 Month and Year of most recent revision: 04, 2008 Ad.8 What is your frequency for review/update of this measure? On-going Ad.9 When is the next scheduled review/update for this measure? 08, 2010</p>
<p>Ad.10 Copyright statement/disclaimers:</p>
<p>Ad.11 -13 Additional Information web page URL or attachment:</p>
<p>Date of Submission (MM/DD/YY): 08/02/2010</p>